



Claims Eval

Notice of Independent Review Decision

June 5, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient Surgery: Shoulder Arthroscopy 29827,29823,29826,29824,23440

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

American Board of Orthopaedic Surgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- 12-19-12 MRI of the left shoulder.
- 1-29-13, office visit.

- 2-12-13, office visit.
- 3-19-13, office visit.
- 3-27-13 UR.
- 4-11-13 UR request for reconsideration for outpatient surgery for shoulder arthroscopy.
- 4-2-13, office visit.
- 4-19-13 UR.
- 4-22-13 UR notification of adverse determination.

PATIENT CLINICAL HISTORY [SUMMARY]:

12-19-12 MRI of the left shoulder shows partial insertional tear of the subscapularis tendon. Mild bursitis and rotator cuff tendinopathy. Moderate severity glenohumeral arthrosis with degenerative tear of the labrum. Associated biceps tendinopathy and longitudinal split tear.

1-29-13, the claimant is a individual who presents for evaluation and consultation regarding a work-related injury which occurred to his left shoulder on xx/xx/xx. At that time, the patient was picking up cans and he noted a "pop". Since that time, he has had pain with overhead activity. He notes pain when he sleeps on the affected side. He has no sustained numbness or tingling of the hand. He did undergo physical therapy without any appreciable relief. He has also undergone an MRI scan and this is available for viewing. Of note was that of a partial thickness rotator cuff tear involving the supraspinatus and subscapularis tendon tear. The supraspinatus was involved anteriorly. A biceps tendon split tear was also noted with tendinosis. Acromioclavicular joint hypertrophic changes were noted. He has been completing modified work activity. He presents today for further evaluation. Examination of the neck revealed a negative Spurlings sign. No evidence at this time of radiculopathy was noted. No significant tenderness at Erb's point. No paraspinal muscle spasm in the cervical spine region. No bony tenderness posteriorly. No crepitations with range of motion. Examination of the hand revealed the median, radial and ulnar nerves to be intact and functional. Examination of the elbow did not reveal significantly limited range of motion. The range of motion was symmetric with the contralateral side. Examination of the left shoulder revealed forward elevation to 160°, external rotation to 55°, internal rotation to the T12 level. This caused discomfort. Positive impingement sign, positive cross arm adduction test. Tenderness was noted over the acromioclavicular joint and the biceps tendon. Internal and external rotation of the arm at the side revealed crepitations within the subacromial space. Rotator cuff strength testing in both forward elevation, abduction and external rotation showed

strength deficit although no obvious substitution was noted. No evidence of rotator cuff arthropathy. No high riding of the humeral head, Examination for Instability did not reveal an apprehension sign either in the anterior nor the posterior direction. No obvious muscular atrophy was noted about the shoulder. No significant swelling. No bruising was noted about the skin. No scapular winging was appreciated. Lift off test was negative. Radiographs revealed acromioclavicular joint hypertrophic changes. Minimal early changes were noted surrounding the glenohumeral joint area. A type 2 acromion was noted. Assessment: Left shoulder partial thickness rotator cuff tear involving superior portion of the subscapularis tendon, supraspinatus tendon anteriorly with biceps tendon spilt tear with tendinosis acromioclavicular joint hypertrophic changes creating medial outlet stenosis. Plan: He explained the nature of the diagnosis and possible treatment options. At this time he would recommend that he continue with conservative care. The patient was given instructional information and a demonstration of appropriate Thera-Band resistance band shoulder exercises. This included internal, external, and abduction stretching and strengthening exercises for the rotator cuff and supporting shoulder girdle musculature. The frequency and number of repetitions were also discussed and questions answered. After discussing the risks and benefits the lateral aspect of the left shoulder was sterilely prepped. A mixture of 6 cc. 1% Lidocaine Plain and 3 cc. of Depo-Medrol was then instilled into the subacromial space utilizing a 22-gauge needle. This was well tolerated and was deemed a medical necessity for this patient. This did give him good immediate relief suggesting he is having pain from this area. Work activity will include that of avoiding overhead lifting. He can lift to 5 pounds. He will be seen in clinical follow up in two weeks. Because his MRI scan does show substantial changes, if he does continue to have problems, he may consider further intervention. He was also given literature on his diagnosis.

2-12-13, the claimant has been completing home exercises. He did have a cortisone injection during his last visit. This gave him minimal relief. He is presently working. He still has significant discomfort. On physical examination, he continues to have a positive impingement sign and a positive cross arm adduction test. Crepitations were noted in the subacromial space. He elevated to 160 degrees, external rotation to 55 degrees. Assessment: Left shoulder partial thickness rotator cuff tear involving superior portion of the subscapularis tendon, supraspinatus tendon anteriorly with biceps tendon split tear with tendinosis, acromioclavicular joint hypertrophic changes creating medial outlet stenosis. Plan: He will continue at this time with his range of motion exercises. He will continue with avoiding overhead lifting. He will lift less than 10 pounds. He will be seen in clinical follow up in four weeks. If at that point he is not making progress, he will consider a decision regarding further intervention.

3-19-13, the claimant presents for a follow up. He has been completing range of motion exercises. He has undergone a cortisone injection. His shoulder at this point is not making any substantial progress. He has actually had increasing pain since he was last seen on 02/12/2013. On physical examination, again, a positive impingement sign and a positive cross arm adduction test were noted. Significant crepitations were noted in the subacromial space. Mild substitution was noted with

abduction strength testing. He elevated today to 150 degrees, external rotation to 45 degrees. Lift-off test did reveal pain. Tenderness over the acromioclavicular joint and the biceps tendon. Assessment: Left shoulder partial thickness rotator cuff tear involving superior portion of the subscapularis tendon, supraspinatus tendon anteriorly with biceps tendon split tear with tendinosis, acromioclavicular joint hypertrophic changes creating medial outlet stenosis. He discussed the further options. It has been greater than three months since his injury. He has a substantial partial thickness tear. He has undergone cortisone injections, range of motion exercises, anti-inflammatories, and activity avoidance. He has not made progress. At this time his shoulder examination still exhibits weakness. He has fulfilled the ODG Guidelines. At this point, the other options include that of arthroscopic examination of the left shoulder with indicated procedures including debridement, subacromial decompression, distal claviclectomy, arthroscopic with rotator cuff repair, biceps tendon groove plasty. He discussed the risks which include, but are not limited to, nerve and artery damage, infection, complications including those from anesthesia and failure to relieve the patient's discomfort and possible need for further procedures if symptomatic improvement was not noted and/or complications were to arise. The patient was given literature concerning the procedure and the questions were answered in detail. The rehabilitation process was also discussed. At this time, he wishes to consider proceeding. He will appeal to the industrial carrier for authorization. He was given a prescription for Tramadol. In the interim, he will continue with his present modified work activity.

3-27-13 UR, notes non certification for the requested procedure. The reviewer noted that he attempted a peer discussion with but was not able to reach him. Without peer review he could not recommend approval of the proposed surgery as medically indicated or necessary at this time. He did not feel that he has exhausted conservative care with physical therapy, oral steroids and pain medications. The MRI shows degenerative changes of the shoulder and moderate to severe glenohumeral arthritis with a degenerative tear of the labrum and associated biceps tendinopathy and longitudinal split tear. Given the above, and without peer discussion, based on the MRI findings of 12/19/12 and consistent with the evidence based medicine, he could not recommend approval of the surgery as medically necessary.

4-11-13 UR request for reconsideration for outpatient surgery for shoulder arthroscopy.

4-2-13, the claimant presents for a follow up. Evidently the industrial carrier did not authorize surgical intervention. They requested a peer-to-peer review. The reviewer also suggested oral steroids. The reviewer also felt that the patient had not been treated to a conservative extent. With respect to shoulder, he continues to have difficulty. He is having more pain at this time with overhead activity. He is having more pain at night. On exam, again, a positive impingement sign and a positive cross arm adduction test were noted. He had crepitations in the subacromial space area along with a palpable click. Abduction strength testing revealed weakness associated with substitution. Elevation to 145 degrees, external rotation to 50

degrees. Lift-off test at this time revealed pain, but he did not have weakness. No muscular atrophy surrounding the shoulder region. Assessment: Left shoulder partial thickness rotator cuff tear involving superior portion of the subscapularis tendon, supraspinatus tendon anteriorly with biceps tendon split tear with tendinosis, acromioclavicular joint hypertrophic changes creating medial outlet stenosis. Plan: He again discussed the further options. With respect to treatment, he has undergone anti-inflammatories, a cortisone injection, home exercises, formal supervised physical therapy, and activity avoidance. He has not noted any relief. It has been greater than three months since his injury. He has exceeded the ODG Guidelines. The suggestion of oral steroids is not recommended. Oral steroids have a high complication rate, including that of avascular necrosis of the hips. His MRI scan shows a split tear of the biceps tendon along with a significant grade partial thickness rotator cuff tear. He does not have substantial degenerative changes within the glenohumeral joint and is not being treated for degenerative changes. Again, he has not responded to conservative care. All of the information is included above. A peer-to-peer review will not add any information as he had included it all above.

4-19-13 UR non certification for surgery requested. The evaluator noted the requested right and left shoulder arthroscopy including rotator cuff repair, debridement, subacromial decompression, and distal claviclectomy are not supported as medically necessary based on the clinical documentation submitted for review and current evidence based guidelines. Clinical documentation does not demonstrate an extensive course of conservative treatment. Although the patient had a subacromial space injection in 01/13, there was no significant response to the injection which questions whether all pain generators have been accurately identified for the patient. There is no documentation regarding a reasonable course of conservative treatment including physical therapy and, given the lack of any rotator cuff tearing on MRI, physical therapy would be supported before surgical consideration is made. Also, the imaging studies did not reveal any evidence of a significant rotator cuff tear that would reasonably require repair at this time. As the clinical documentation does not discuss a reasonable course of conservative treatment and there is lack of imaging to support some of the requested services, medical necessity would not be established at this time.

4-22-13 UR notification of adverse determination.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Medical records reflect the claimant is having more pain at this time with overhead activity. He is having more pain at night. On exam, it is noted the claimant has a positive impingement sign and a positive cross arm adduction test were noted. He had crepitations in the subacromial space area along with a palpable click. He has undergone anti-inflammatories, a cortisone injection, home exercises, formal supervised physical therapy, and activity avoidance. Based on the records provided,

reasonable nonoperative treatment has been fully tried and failed. Therefore, the outpatient Surgery: Shoulder Arthroscopy 29827, 29823, 29826, 29824, 23440 is reasonable and medically necessary.

Per ODG 2013 ODG Indications for Surgery™ -- Rotator cuff repair:

Criteria for rotator cuff repair with diagnosis of full thickness rotator cuff tear AND Cervical pathology and frozen shoulder syndrome have been ruled out:

1. Subjective Clinical Findings: Shoulder pain and inability to elevate the arm; tenderness over the greater tuberosity is common in acute cases. PLUS
2. Objective Clinical Findings: Patient may have weakness with abduction testing. May also demonstrate atrophy of shoulder musculature. Usually has full passive range of motion. PLUS
3. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary views. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.

Criteria for rotator cuff repair OR anterior acromioplasty with diagnosis of partial thickness rotator cuff repair OR acromial impingement syndrome (80% of these patients will get better without surgery.)

1. Conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS
2. Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees. AND Pain at night (Tenderness over the greater tuberosity is common in acute cases.) PLUS
3. Objective Clinical Findings: Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS
4. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.

(Washington, 2002)

ODG Indications for Surgery™ -- Ruptured biceps tendon surgery:

Criteria for tenodesis of long head of biceps (Consideration of tenodesis should include the following: Patient should be a young adult; not recommended as an independent stand alone procedure. There must be evidence of an incomplete tear.) with diagnosis of incomplete tear or fraying of the proximal biceps tendon (The diagnosis of fraying is usually identified at the time of acromioplasty or rotator cuff repair so may require retrospective review.):

1. Subjective Clinical Findings: Complaint of more than "normal" amount of pain that does not resolve with attempt to use arm. Pain and function fails to follow normal course of recovery. PLUS
2. Objective Clinical Findings: Partial thickness tears do not have classical appearance of ruptured muscle. PLUS

3. Imaging Clinical Findings: Same as that required to rule out full thickness rotator cuff tear: Conventional x-rays, AP and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.

Criteria for tenodesis of long head of biceps with diagnosis of complete tear of the proximal biceps tendon: Surgery almost never considered in full thickness ruptures. Also required:

1. Subjective Clinical Findings: Pain, weakness, and deformity. PLUS

2. Objective Clinical Findings: Classical appearance of ruptured muscle.

Criteria for reinsertion of ruptured biceps tendon with diagnosis of distal rupture of the biceps tendon: All should be repaired within 2 to 3 weeks of injury or diagnosis. A diagnosis is made when the physician cannot palpate the insertion of the tendon at the patient's antecubital fossa. Surgery is not indicated if 3 or more months have elapsed.

(Washington, 2002)

ODG Indications for Surgery™ -- Partial claviclectomy:

Criteria for partial claviclectomy (includes Mumford procedure) with diagnosis of post-traumatic arthritis of AC joint:

1. Conservative Care: At least 6 weeks of care directed toward symptom relief prior to surgery. (Surgery is not indicated before 6 weeks.) PLUS

2. Subjective Clinical Findings: Pain at AC joint; aggravation of pain with shoulder motion or carrying weight. OR Previous Grade I or II AC separation. PLUS

3. Objective Clinical Findings: Tenderness over the AC joint (most symptomatic patients with partial AC joint separation have a positive bone scan). AND/OR Pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial. PLUS

4. Imaging Clinical Findings: Conventional films show either: Post-traumatic changes of AC joint. OR Severe DJD of AC joint. OR Complete or incomplete separation of AC joint. AND Bone scan is positive for AC joint separation.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- INTERQUAL CRITERIA**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**